



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator  
DIVISION OF MEDICAID  
Post Office Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

February 6, 2008

Anna Ong, Administrator  
Beehive Home Arlington-Assisted Living Centers Inc  
5521 West Hollilynn Drive  
Boise, ID 83709

License #: RC-893

Dear Ms. Ong:

On January 3, 2008, an initial licensure survey was conducted at Beehive Home Arlington-Assisted Living Centers, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Maureen McCann, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

MAUREEN MCCANN, RN  
Team Leader  
Health Facility Surveyor  
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor  
RICHARD M. ARMSTRONG - Director

LESLIE M. CLEMENT - Administrator  
DIVISION OF MEDICAID  
Post Office Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

January 8, 2008

Anna Ong, Administrator  
Beehive Home Arlington-Assisted Living Centers Inc  
5521 W Hollilynn Drive  
Boise, ID 83709

Dear Ms. Ong:

On January 3, 2008, an Initial Licensure survey was conducted at Beehive Home Arlington-Assisted Living Centers, Inc. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by February 3, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP  
Program Supervisor  
Residential Community Care Program

JS/sc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>13R893</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/03/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEEHIVE HOME ARLINGTON-ASSISTED LIVIN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3123 ARLINGTON CALDWELL, ID 83605</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>Initial Comments</b></p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the initial survey conducted at your facility. The surveyors conducting the initial survey were:</p> <p>Maureen A. McCann, RN Team Coordinator Health Facility Surveyor</p> <p>Rachael Corey, RN, BSN Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p>	R 000		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

14ER11

If continuation sheet 1 of 1



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-6626 fax: (208) 364-1888

I of III

ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <i>Beehive Home Arlington</i>	Physical Address <i>3123 Arlington</i>	Phone Number <i>208-455-7857</i>
Administrator <i>Anna Ong</i>	City <i>Caldwell</i>	ZIP Code <i>83604</i>
Survey Team Leader <i>Maureen McCann</i>	Survey Type <i>Initial</i>	Survey Date <i>01/03/08</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	15.02.a	Staff did not respond to a medical emergency according to the facilities emergency policy.	1/29/08	Muc 2/4/8
2	310	The facility did not implement their activity policy.	1/4/08	Muc 2/4/8
3	305.01	Residents #1 and #2 did not have a nursing assessment for bedrails.	1/12/08	Muc 2/4/8
4	305.02	The facility nurse did not ensure PRN medications were available as ordered for Residents #1, 2 & 3 (standing orders), medication orders were transcribed accurately on the MAR for Resident #2, a verbal order was signed by the physician for Resident #2 and medication for Resident #2 & #3 they were no longer taking had no discontinuance orders. (meds on MAR not d'cd.)	1/29/08	Muc 2/4/8
5	310.01.d	Staff were administering liquid medications to Resident #2 that was not in compliance with BON rules.	1/29/08	Muc 2/4/8
6	310.04.e	The facility is not coordinating psychotropic medication reviews (6 months) with the physician for Residents #1 & #2.	1/23/08	Muc 2/4/8
Response Required Date <i>2/3/08</i>		Signature of Facility Representative <i>Anna M Ong</i>	Date Signed <i>1/3/08</i>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

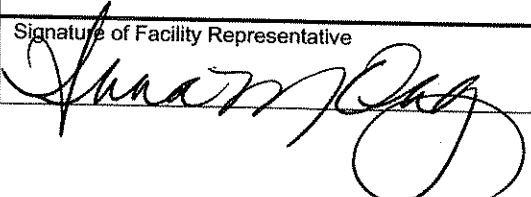
BUREAU OF FACILITY STANDARDS  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-6626 fax: (208) 364-1888

II of III

ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <b>Beehive Home Arlington</b>	Physical Address <b>3123 Arlington</b>	Phone Number <b>455 7857</b>
Administrator <b>Anna Ong</b>	City <b>Caldwell</b>	ZIP Code <b>83604</b>
Survey Team Leader <b>Maureen A. McLean</b>	Survey Type <b>Initial</b>	Survey Date <b>1/3/18</b>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
7	320.01	Residents 1, 2 + 3 were not assisted with eating as described in their NSA's; Outside services (Hospice) were not described on Resident #'s 1 + 2's NSA's to include frequency of services, and how such services are to be delivered.	1/26/08	MM 2/4/18
8	350.07	2 reportable incidents regarding Res #3 were not forwarded to the Bureau within 24 <sup>hrs</sup> .	1/29/08	MM 2/4/18
9	625.01	1 of 2 staff did not receive 16 <sup>hrs</sup> of orientation training within 30 days.	1/26/08	MM 2/4/18
10	630.01	2 of 2 staff did not receive department training.	1/29/08	MM 2/4/18
11	711.02	The facility did not maintain a complaint log.	1/4/08	MM 2/4/18
Response Required Date <b>2/3/18</b>			Signature of Facility Representative 	
			Date Signed <b>1/3/08</b>	



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-6626 fax: (208) 364-1888

III of III

ASSISTED LIVING  
Non-Core Issues  
Punch List

Facility Name <i>Beehive Home Arlington</i>	Physical Address <i>3123 Arlington</i>	Phone Number <i>455-7857</i>
Administrator <i>Anna Ong</i>	City <i>Caldwell</i>	ZIP Code <i>83604</i>
Survey Team Leader <i>Maurice Melam</i>	Survey Type <i>Initial</i>	Survey Date <i>1/3/08</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
12	550.02	Residents were not <del>at</del> ensured privacy with the usage of an intercom call system.	1/24/08	<i>me 2/4/08</i>
13	450	The facility did not meet the standards of the Idaho Code. (See food inspection report for details).	1/4/08	<i>me 2/4/08</i>
<div></div>				

Response Required Date

Signature of Facility Representative

Date Signed

*2/3/08*

*Anna Ong*

*1/3/08*